SENTARA®

Mammography Questionnaire

Name ______________________ Date: ____________ Birth Date ____________ MRN ____________

Referring M.D. ______________________ GYN M.D. ______________________

If we need to contact you for additional imaging, what telephone number(s) and/or email can we use to contact you?

Home ____________ Work ____________ Cell ____________

Email ______________________

What is the reason you are having a breast imaging exam?
- ☐ Routine screening. I have no current breast problems.
- ☐ I am here for a follow-up from a prior visit (3 mo, 6 mo)
- ☐ I am here for a new breast problem. ____________

☐ Yes ☐ No Do you have medication pump?

☐ Yes ☐ No Are you or could you be pregnant?

☐ Yes ☐ No Is this your first mammogram? If no, where and when did you have your last mammogram? ____________

Last menstrual period ____________

Age your period began ____________

Age at menopause ____________ ☐ N/A

Number of pregnancies ____________

Number of children you gave birth to ________

Age at first full term pregnancy ____________ ☐ N/A

Have you had breast trauma (i.e. bruises) in the last year? ☐ Yes ☐ No

Breast-fed in last 3 months? ☐ Yes ☐ No

Have you had a weight change of > 10 lbs since your last visit? ☐ Up ☐ Down

If you have implants please answer for following:
- ☐ Silicone ☐ Saline ☐ Left
- ☐ Prepectoral ☐ Retropectoral ☐ Right

Month/Year ____________

Are you Ashkenazi Jewish? ☐ Yes ☐ No

Women of Ashkenazi Jewish descent have a higher risk of developing breast cancer

HISTORY

Have you ever had a hysterectomy or your ovaries removed?

Hysterectomy: ____________

Ovaries removed: ____________

Have you ever had breast surgery? ☐ Left ☐ Right ☐ Both

Mastectomy, lumpectomy, biopsy, cyst aspiration, or reduction for example.

____

Have you ever used contraceptives? What kind? When? How long?

(Oral, Depo Provera, Nuva Ring, Norplant, the patch)

____

Have you ever taken hormones? Indicate if currently using or in the past?

(Estrogen, Premarin, Provera, Tamoxifen, Arimidex, Femara, Megace, Lupron)

____

Have you ever had chemo or radiation therapy? What kind? When?

____

____

Have you ever had breast cancer? What type?

When: ____________

Which Breast: ____________

Have you had any ovarian cancer?

When: ____________

Family history of breast, ovarian, or other cancer?

Mother, father, sisters, brothers, aunt, grandmother? Indicate age of diagnosis

Age of Relative ____________

What type? ____________

____

Have you been tested for BRCA? (Breast Cancer Gene) ☐ Yes ☐ No

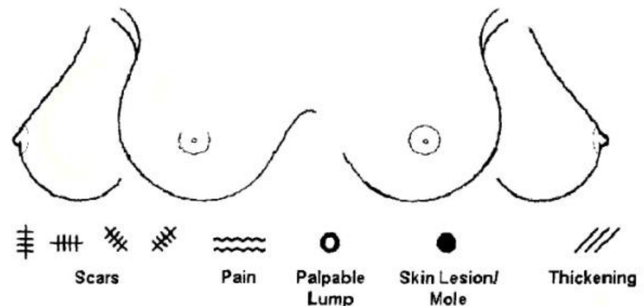
If so, was it positive or negative? ☐ Pos ☐ Neg

Do you or any family members carry a gene mutation that causes an increased risk for breast cancer? (examples of these genes: BRCA1, BRCA2, PTEN, P5, STK11)

____

____

Technologist Fill Out Only Tech Initials ________



Tech comments: ____________

____

List additional views: ____________

____

____

I the undersign give Sentara Breast Center, permission to obtain my prior mammograms, reports, and permission to obtain my confidential record (follow-up breast surgery, pathology and or consultation notes).

I acknowledge this information I have provided is accurate to the best of my knowledge.

Patient Signature: ______________________ Date: ____________

SENTARA®

CONSENT TO PERFORM MAMMOGRAPHY, ACKNOWLEDGEMENT OF MAMMOGRAPHY LIMITATIONS, AND PATIENTS RESPONSIBILITIES

I consent to the performance of a mammogram.

I understand that a mammogram, whether baseline or screening, represents an important link to continued good health as recommended by the American Cancer Society. Your mammogram was performed by a Registered Radiologic Technologist, on a dedicated X-ray Unit and will be interpreted by a qualified Radiologist in a facility fully accredited by the American College of Radiology and Mammography program.

There is a possibility that in the interpretation of your mammogram, follow-up studies may be necessary, including additional specialized mammographic views or ultrasound. These extra views and procedures do not necessarily indicate a problem but may be necessary to interpret more completely the findings on your mammogram.

I understand that a mammogram does not substitute for a physical examination by a physician and that a mammogram is most informative when obtained in conjunction with a physical breast examination. I understand that a normal mammogram does not conclusively rule out the presence of breast disease and does not detect all breast cancers. Further, I understand that it is my responsibility to inform any new physicians or new supplier of screening mammography the date and place of previous mammogram.

If a screening mammogram or diagnostic mammogram is performed, I understand that the results of this procedure will be released only to my designated physician and that I should confer with him or her concerning these results. I authorize the release of the copy of the results of this mammogram to DR. ____. I understand that it is my responsibility to seek follow up care should any non-normal results be reported to me.

I confirm that I have reported any symptoms of breast disease, which may be present to the Radiology Technologist performing this mammogram. I further state that I am neither pregnant nor nursing a baby.

PATIENT'S SIGNATURE ____

OR

LEGAL GUARDIAN ____

WITNESS ____

DATE __________________________